HICKORY DENTAL CARE

Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

Dale E. Spencer, D.D.S is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab test/x-rays ☐ Other
☐ Spouse (name) _____	☐ Family billing information ☐ Financial ☐ Medical as follows: _____
☐ Parent (name) _____	☐ Family billing information ☐ Financial ☐ Medical as follows: _____
☐ Other (name) _____	☐ Financial ☐ Medical as follows: _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to *Dale E. Spencer, D.D.S*. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Person Representative's Authority (attach necessary documentation)